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CME

Managing Long-Term Opioid Therapy With Less Stress

Relationships with patients on long-term opioids for chronic pain can be fulfilling rather than frustrating if physicians employ these strategies.

Family physicians are under increasing pressure to generate work Relative Value Units and meet clinical and patient satisfaction metrics, all while providing evidence-based care. It can be challenging to balance all those forces, especially when it comes to management of opioids, which has become a significant part of primary care. By one estimate, approximately 4% of all U.S. adults were prescribed long-term opioid therapy as of 2005.[1] While prescribing rates have fallen since then, millions of Americans are still taking opioids for chronic pain.[2]

There are evidence-based guidelines to help physicians manage these medications,[3] and many patients can get relief from chronic pain and regain quality of life by taking opioids. But some develop

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complications, including physiologic opioid dependence and addiction. This leaves physicians to grapple with the inherent tension in trying to relieve patients' suffering while also doing no harm.

Meanwhile, a cultural backlash against opioids, following years of increasing overdose deaths,[4] further complicates the dilemma. Doctors can feel under scrutiny for prescribing them, even if they're following guidelines. Patients can feel vilified for taking them, even if they're adhering strictly to their doctor's instructions. Both doctor and patient are subject to external societal pressure, which can sadly create an adversarial relationship, leading to stressful, emotionally draining interactions.

It does not have to be that way. We can "deliver patient-centered, compassionate care to patients struggling with chronic pain,"[5] as an American Academy of Family Physicians position paper urges. My practice focuses on addiction medicine and chronic pain, and I've learned some strategies over the years that go beyond the basics of opioid management,[6] making these visits less stressful and more productive.

By following these steps before and during the visit, physicians can be confident they are helping patients and practicing evidence-based medicine, leaving them feeling fulfilled rather than frustrated.

PRE-VISIT PREP

To avoid letting emotion set the tone of an encounter, invest a little prep time in making the visit as patient-centered and objective as possible. The reduction in stress and increase in efficiency will be well worth the time spent.

Set an agenda based on guidelines and objective data. Before the visit begins, spend a short time (often less than 60 seconds) scanning previous notes and considering what you would like to cover:

- What was the previous plan?
- Is the patient meeting goals (e.g., grocery shopping)?
- Are previously recommended interventions improving side effects (e.g., constipation)?
- Are you following current guidelines?[3]
- Did the patient follow through with tasks such as tests and referrals?
- When the nurse called the patient for a random pill count (a rough screen for diversion), was the number as expected?
- Did the patient follow risk-mitigation recommendations, such as filling a naloxone prescription or (if indicated) getting tested for obstructive sleep apnea?

You won't need to answer all of these questions for each patient, but having a well-grounded roadmap based on pertinent data improves adherence and saves time and stress during the visit.

> Having a well-grounded roadmap heading into the visit improves adherence to guidelines.

Identify your "line in the sand." Before you walk in the room, anticipate potential disagreements or conflicts. It is critical to determine what you *recommend* for patients versus what you *require* of them. For example, if a patient missed a physical therapy appointment, most physicians would probably not take drastic action. If physical therapy can help, and the patient doesn't go, it's the patient's loss, not the physician's. Perhaps the patient has been to physical therapy many times with little result at great time and financial cost. But if there are unexpected benzodiazepines in a patient's urine test, that may be a red line that demands intervention before prescribing more opioids, given the dangers of mixing these types of drugs. Every situation is different, and clinicians'

KEY POINTS

- Physicians can take a number of steps before and during visits to defuse tension and maintain fulfilling relationships with patients on long-term opioids for chronic pain.
- Developing a clear agenda based on objective data, balancing emotions, and identifying non-negotiable "lines in the sand" can help physicians prepare for these visits.
- During the visit, key steps include listening with empathy, setting clear expectations, and asking questions to determine if the patient may be taking opioids for emotional or psychological reasons.

perspectives and values vary. The key is to differentiate what you think would be best for the patient from what is actually dangerous or harmful.

Take an emotional inventory, then hit your reset button. You are human, so at times you will feel angry, overwhelmed, or anxious. Those emotions may contribute to a negative mindset going into visits. When you have these emotions, ask yourself: What is making me feel this way? (See "Common examples of opioid-related bias and emotional triggers.") Recognize that a feeling is just a feeling. Once you identify the emotion and what triggered it, leave it at the door. Hit your "reset button," take a deep breath, and walk in the room with a data-driven, evidence-based plan, a clean slate emotionally, and an open mind.

Really hear what the patient is saying, literally, but more importantly, be mindful of the subtext.

DURING THE VISIT

In a busy office, it is easy to become frustrated with a patient who does not seem receptive to our advice. But we must start from the mindset that this is all about the patient, not us. The patient is the one with the disease. The patient is the one suffering. On occasion, I'll compassionately yet directly tell a patient, "It's your life. I'm just here to support you. This is about you, not me." Admittedly, I say this not just for the patient, but also for my benefit. It keeps me grounded and reminds me that there is no reason I should get upset or angry if a patient does not follow my recommendations.

Practice empathy: listen, process, and validate. Really hear what the patient is saying, literally, but more importantly, be mindful of the subtext. Summarize out loud for the patient what you've heard. So much patient frustration stems from a belief that we as physicians don't understand what their real issues are. Validate the patient's feelings and needs, but remember: validation doesn't equal agreement.

Here's an example of what this looks like: Let's say your colleague declined to fill a patient's opioid prescription over the weekend. You believe this decision was correct, but the patient is upset. You could say something like, "It sounds like you were busy at work last week, forgot to call for a refill, and only remembered Saturday. But when you called, the doctor on call declined, and you spent the rest of the weekend in pain. That must have been frustrating. Not only were you in pain, but you felt that the doctor disregarded the pain and that made things worse." This is validating, not agreeing. It shows that you heard the patient clearly. Then you can continue, "I think the doctor was simply following our office protocols. I probably would have done the same because it's our rule, but I can see why you're upset — that makes sense to me. I'm sorry you were in pain and felt ignored."

Ask "What does (prescribed opioid) do for you?" As an addiction medicine specialist, I always ask patients what alcohol or their drug of choice does for them, to explore potential underlying reasons for use. This question is also helpful for patients on prescribed opioids for chronic pain. Most of the time, patients will give an obvious reason, such as, "It helps my back pain so I can play with my grandkids." But if you ask this question to all patients on long-term opioids, you will occasionally get answers such as, "Well, it makes me

COMMON EXAMPLES OF OPIOID-RELATED BIAS AND EMOTIONAL TRIGGERS

Treating patients on long-term opioids for chronic pain can be fraught with emotional reactions that aren't always based on objective evidence. Here are some examples.

- *"The last patient like this put me way behind."*
- *"He always has some excuse for not going to physical therapy."*
- *"I hate feeling manipulated."*
- *"Whenever I refill his opioids, I feel the nurses are judging me."*
- *"I don't think she needs this opioid, but what's the alternative?"*
- *"The pain management doctor said opioids are not necessarily indicated but then said he will not see the patient again; that gets me so angry. What am I supposed to do?"*
- *"I inherited this mess; it's just not fair."*

feel better," "It helps me relax," or "It helps me sleep" (independent of treating pain). Patients who answer in this way are often *subconsciously* using opioids for non-physical reasons. Most of them are not intentionally misusing the medication, but there is so much overlap between physical and emotional pain.

These sorts of answers can spark further discussions to explore anxiety, insomnia, depression, and previous trauma. This can lead to more effective treatment and may allow patients to decrease their opioid dose or even discontinue opioids entirely.

Develop a plan, set expectations, and stick to them. After collecting data from the patient, make a fair, clear, mutually agreed-upon plan that is individualized but follows evidence-based guidelines. Include non-opioid medications, non-medication treatments, and treatment for mental health issues, such as anxiety, that often accompany pain. When patients seem apprehensive about the plan, it's worth having difficult conversations with them to secure buy-in (see "Starting difficult conversations").

As you form the plan, make *required* tasks crystal clear. If you tell a patient, "You should see psychiatry," and at the next visit you discontinue opioids because he or she didn't see psychiatry, the patient may be understandably upset. The consequences of non-adherence were not clear, and the referral sounded like a suggestion, not a mandate. It's more effective to say something like, "We will continue the oxycodone. But I am worried that anxiety may be making your pain worse. Therefore, as we discussed, by our next visit you need to let me know you have an appointment with psychiatry to be evaluated. If I don't have at least the date and name of an appointment in the future, I won't refill the oxycodone."

I dictate instructions into the after-visit summary while in the room in front of the patient. This is partially for the sake of efficiency, but also so that if the patient doesn't follow through on something, it is obvious who dropped the ball.

Once you've made a plan and ensured that the patient understands it, you both have to adhere to it. Be prepared to politely stand your ground if a patient crosses your line in the sand. When I have followed all the above steps and a patient does cross the line, I can calmly and justifiably say something like, "I will not refill the oxycodone. We discussed that the lorazepam you are getting from your neighbor can interact with the oxycodone and you can die. Your safety is paramount." I always say, "I will not refill it," or "I can't in good conscience refill it." I never say "I can't refill it," because I *can* refill it, and patients know that. Being disingenuous degrades trust. There is nothing wrong with withholding a prescription or any other intervention for valid clinical reasons, so physicians shouldn't feel hesitant to tell patients that's what they're doing. ➤

STARTING DIFFICULT CONVERSATIONS

The following phrases can help physicians begin conversations with patients about opioid-related care plans.

- *"Given [objective findings/concerning behavior], I'm worried … I'd like to get a second opinion from someone who has more expertise with these medications."*
- *"We have talked about risks of dependence and hyperalgesia. I'm worried opioids may be causing more pain in the long run … I'd like to get a second opinion …"*
- *"A pain management specialist is best able to help you. They have the most experience limiting the tolerance you have developed. Why wouldn't you want to see them? Help me understand."*
- *"This is the second month in a row you ran out of oxycodone early. It is common for bodies to adapt to pain medications and need more over time, but people can also develop dependence. I would like you to see a colleague who can help us determine the next best steps."*
- *"You have had cocaine in your urine, and our contract covers these issues — not as a punishment but as a safety precaution given the prevalence of cocaine contaminated with fentanyl. I want to help and support you, but I need to do what's right for your safety."*
- *"I realize your previous doctor prescribed these differently than I want to prescribe them, but guidelines and recommendations change over time. I want to be sure we are using these as safely as possible. Let's figure out a way we can make this work."*
- *"I am happy to refill your current dose because I don't want you to be without medication, but this is temporary until we get you in the hands of someone who may be able to better assist you. I will reach out to some colleagues to figure out the best plan."*
- *"Some of my other patients have terrible, ongoing physical pain for which we are doing [X, Y, and Z], but in addition they tell me they get angry or anxious about the pain. Do you ever notice that in yourself?"*
- *"The pain is severe and real, but while we are also taking care of that, can we address the pain's impact on your life?"*

Do not abandon patients. Concerning developments, such as an unexpected result on a drug test, should be the start, not the end, of a conversation with your patient on long-term opioids.

Imagine a patient has diabetes and her A1C bumps up from 7.2 to 9.4. Should her physician say "Mrs. Smith, you messed up. We're done, and you need to seek another physician"? Of course not. Yet some clinicians dismiss patients on long-term opioids if there is an unexpected urine drug screen result. That is when patients need their primary care doctor the most, to support them emotionally, examine external stressors and problems that may be contributing to non-adherence, and connect them with other physicians or providers who can help them, if necessary.

This does not mean blindly continuing opioid prescriptions — the patient's safety is paramount. But it means assisting and not abandoning the patient. If an "opioid contract" is broken, we need to work to understand how and why, even if those conversations are uncomfortable.

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

SUMMARY

Opioid use and management is an emotionally charged issue at times. But if we remember to keep the focus on patients and their safety and well-being, adhere to guidelines, create objective plans, and have direct yet compassionate conversations, our relationships with patients on long-term opioid therapy can be gratifying and effective. FPM

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